May 25, 2016

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

RE: Direct Provider Contracting Request for Information

Dear Administrator Verma, Deputy Administrator Boehler, and CMMI team members,

I am not a physician. But, I do have a very extensive background in Direct Primary Care ("DPC"), and, thus, offer a unique and valuable perspective.

I have been intimately involved in the creation and management of standalone DPC clinics, as well as the Founding Partner of a 50+ physician-member "DPC network" called Forthright Health Management LLC ("Forthright Health"). I thank you for your willingness to listen.

Back in late 2011, I joined with Dr. Jeffrey Huotari, Family Medicine physician and owner of BlueSky Health PLLC ("BlueSky"), in order to build Dr. Huotari's second BlueSky location – BlueSky Health of Howell, MI: the first standalone DPC clinic in Michigan. I served as BlueSky's Chief Operating Officer with the purpose of forming partnerships with employers and other payers, and in hopes of building additional BlueSky facilities.

The lessons of my time with BlueSky led me to form Forthright Health in late 2014. The purpose of Forthright Health was twofold: (1) to create a large enough footprint of Primary Care physicians willing to contract directly with and service the geographically dispersed needs of self-insured employers, and, (2) provide the >90% of Primary Care physicians who had no interest in "opting-out" of Medicare a way to experiment with DPC without sacrificing their existing patient relationships and/or financial wellbeing. Thus, Forthright Health allows for participating Primary Care physicians to establish DPC relationships while they continue to operate in a primarily fee-for-service environment.

Hence, based upon my own trial and error, if you take only one thing away from my words written here, I hope it will be this: **for DPC to deliver higher quality care, lower cost, and attract physicians and patients, one must make a CMS sponsored DPC program as SIMPLE AND EASY as humanly possible for participating physicians and patients.**

If your DPC program follows the path of CPC+ and ACOs, it will fail.

Therefore, calibrate your program expectations accordingly. Please focus on progress, not perfection. Do not try to have every T crossed and i dotted before launching the DPC program. Start with something as simple as possible. Do not have 80 pages of rules to start (nor even 15 pages). If problems arise and adjustments need to be made, you can do so later. Give physicians the room to innovate and respond in ways we cannot predict today.

Questions Related to Provider/State Participation

Keep it simple, simple, simple. I cannot write SIMPLE enough times. If your desire is to attract a wide variety of practices in constructing a DPC program, you must think about a day-in-the-life of a solo practitioner. She is extremely busy caring for a patient panel of 2,500. Any further complication will likely cause one of two reactions from her: (1) she will say "the hell with CMS", and seek ways to no longer care for Medicare and/or Medicaid patients, or, (2) she will ignore the new program altogether.

Therefore, what do I mean by "simple"?

1. There should be no requirements to join an ACO, network, group, or other collective arrangement.
2. There should be no requirements on use of EHR technology, certain organizational structure requirements, certain safeguards, minimum percent of revenue, experience with patient enrollment, staffing or staff competencies, level of risk assumption, repayment/reserves.
3. Instead of creating rules and barriers, please focus your efforts at CMS on <u>helping</u> – help the physicians care for the program participants by:
    - Promoting the program to patients/beneficiaries
    - Identifying which patients are participating
    - Providing individual (non-aggregate) data on what other CMS-paid services the participating patients are utilizing (e.g. if a patient sees a sub-specialist or visits the ED, you would alert the DPC participating Primary Care physician of such)

As it relates to your question about Medicaid specifically, a financially successful DPC program within the state of Michigan's Medicaid program is impossible.

Why? The financial constraints do not allow for a DPC program to improve Primary Care quality *AND* reduce overall Medicaid cost.

How so? Michigan ranks near the bottom of total Medicaid spending per enrollee – especially in the cases of able-bodied, non-aged adult enrollees. Through my conversations with Managed Care Organization (MCO) executives who implement the Medicaid program for the state, the MCOs have roughly $170 per-enrollee-per-month to spend on all of the enrollee's healthcare needs. Now, if one were to implement a DPC program within Medicaid in Michigan, it would require roughly $70 of the $170 to be paid to the participating Primary Care physician (much higher than typical MCO Primary Care capitation rates of $15-20). Despite the great care that the Primary Care physician would provide the Medicaid enrollee, it is statistically impossible to reduce non-Primary Care utilization enough so that the remaining $100 could adequately cover such needs across all of the MCO's enrollees.

Questions Related to Beneficiary Participation

If you want widespread beneficiary participation, you must make the program simple and easy for beneficiaries. Therefore:

- Beneficiaries should have full control over where the per-beneficiary-per-month ("PBPM") payment may be spent – similar to how food stamp recipients can use their benefits at any participating grocery store
- No copays and coinsurance at the Primary Care level for participating beneficiaries
- The PBPM payment should count against the Part B deductible as further incentive for beneficiaries to participate
- Beneficiaries should have access to an easy-to-understand online directory of participating Primary Care physicians that lists basic information about each physician in addition to the unique services that each participating physician includes for the PBPM payment (some physicians might offer lab tests, imaging, communication technology, integrative services, etc. all covered under the PBPM payment in order to compete for program participating beneficiaries)

Full control over how to use the PBPM payment would mean that participating beneficiaries could enroll and disenroll with any Medicare participating Primary Care physician at any time. However, in order to make it simple and easy for everyone to understand and without the need to remember specific enrollment dates, I would make the PBPM payment correspond to a calendar month. Therefore, if a beneficiary decides to enroll with a participating Primary Care physician on May 11th, the Primary Care physician would receive the PBPM payment for the full month of May. Should the beneficiary decide that they want to see a different Primary Care physician later in that same month, the beneficiary would have to pay out-of-pocket for the month of May with that second Primary Care physician. Then, in the month of June, the beneficiary would, once again, have access to the Medicare PBPM and could either use it to continue enrollment with the second Primary Care physician or the beneficiary could use it to enroll with a new (third) Primary Care physician.

As for "ramp up" time needed, I would recommend a large CMS-managed marketing campaign lasting a full year. The messaging to beneficiaries would go something like this: "starting in 2020, all of your Primary Care needs will be covered with a simple, flat monthly voucher that you control. You can use the voucher at any participating Primary Care physician's office of your choice. See your physician as many times as you want for no copay and no coinsurance. Participating physicians will compete with each other to better meet your needs by offering new services and ways to communicate with you. Go to CMS.gov to see a full list of participating physicians and what unique services they offer for your flat monthly voucher."

Questions Related to Payment

If you want widespread physician participation, you must make the program simple and easy for physicians. Therefore:

- The PBPM payment should cover all of the care a Primary Care physician traditionally provides within the four walls of her office, which should include: diagnosis and treatment of new conditions, ongoing prevention, wellness counseling, disease management, and some reasonably low-cost procedures and tests like rapid strep tests, pregnancy tests, suturing of wounds, wart removals, punch biopsies, and blood draws (but not the pathology lab test)
- The PBPM payment should NOT cover vaccines, medications, or procedures that are costly to procure for the physician
- Make the PBPM payment high enough to cover the cost of providing Primary Care for the physician (it should be at least $40 since the average amount patients spend on Primary Care every year adds up to around $35 per-patient-per-month)
- Make the program simple, do NOT risk-adjust or geographically-adjust the PBPM payment; simply make the payment high enough as an attractive incentive for physicians to care for <u>all</u> beneficiaries; make the payment flat and easy to know for everyone involved

As long as the care covered and not covered is clearly spelled out for the participating physicians, the downside risk for physicians should be limited. We are talking about Primary Care here, not oncology treatments or cardio-thoracic surgery. Therefore, since downside risk is inherently limited at the Primary Care level, all participating physicians should be at risk financially. Risk is a powerful incentive for physicians to attract more participating beneficiaries (in order to smooth-out the risk) as well as force physicians to innovate on how best to care for patients.

As an idea, if you feel that you absolutely MUST risk-adjust the PBPM payment, I would recommend that it be adjusted based on the treatment difficulty of the patient rather than the age, locality, condition, etc. of the patient. To expand upon this idea, have the physician and patient separately rate the patient's health and willingness to interact with others. Then, adjust payment upward for those patients who have difficult personalities or have little interest in interacting with physicians or complying with recommendations.

Questions Related to General Model Design and Questions Related to Program Integrity and Beneficiary Protections

Questions 13 through 20 implicitly speak to what the existing participants in the nationwide DPC movement *hate* about CMS and other payers. Payers are noble in their quest to track and measure compliance and quality, yet, physicians feel like "Big Brother" is watching their every move and demanding paperwork the size of a car loan application in order to receive payment for the simplest of services.

CMS needs a better definition of "quality" and a DPC program is the perfect means to implement that new definition.

Instead of measuring inputs, measure outcomes. The International Consortium for Health Outcomes Measurement (ICHOM) has a list of metrics much more in line with values of patients and Primary Care physicians.

Better yet, collect the metrics through patient reported means. With the technology of today, simple surveys delivered over the phone, online, or in the physician's office can be easily administered.

To simplify further, think about what you would like Primary Care to achieve. In my opinion, Primary Care should focus on two things: (1) keeping people out of the hospital, and, (2) helping people to achieve a point where they are satisfied with their current health. If Primary Care physicians are keeping people out of the hospital and people feel like they are able to live a happy, satisfied life at their age and condition, then a Primary Care physician has done her job effectively.

Conversely, if a patient is frequently in the hospital and is not satisfied with his health status, then that patient is not receiving effective Primary Care.

The two simple goals I listed can be easily measured through hospital claims data and patient administered surveys. Furthermore, if those first two goals are achieved, the overall cost of care should be lower as well. The concern for cost becomes a positive outcome rather than an input.

You could revolutionize Primary Care in the US if you followed this recommendation.

Questions Related to ACO Initiatives

One of the unique benefits and attractions of DPC is its inherent focus on the individual patient-to-physician relationship. Whereas, the ACO model strips away the individual relationship and focuses on "populations".

All too often, CMS initiatives lead to consolidation and further hospital system control of Primary Care physicians. In the case of ACOs, we are now seeing hospitals tie up Primary Care physicians into ACOs simply to control referrals and without any plans or interest whatsoever to reduce cost and improve quality.

<u>If you fail to make a DPC program simple and easy for physicians and patients, further consolidation is guaranteed!</u> Thus, such a scenario will lead to higher costs, further disenchantment of Primary Care physicians, and even anger.

Please make any CMS DPC initiative as simple and easy as possible for both participating Primary Care physicians and beneficiaries.

I would be happy to clarify or expand upon the ideas included within this letter at any time of your choosing. My contact information is listed below.

All the best,

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